

A 74-year-old male patient was admitted to our hospital for evaluation of recent onset atypical chest pain. His medical history included hypertension, dislipidemia and smoking. Physical examination was unremarkable. The resting electrocardiogram was demonstrated biphasic T waves on lateral derivations. Transthoracic echocardiography showed normal left and right ventricular dimensions and functions. Coronary angiography was planned for the patient. First, right transradial approach tried; but guidewire could not be advanced to ascending aorta. Coronary angiography was performed through the right femoral artery. Multiple attempts to cannulate the left coronary ostium were unsuccessful. The right coronary artery cannulated from its normal ostium in the right sinus of Valsalva. After a very short common main stem, the artery divided into a right coronary artery, and separate left anterior descending artery and circumflex artery (Figure A). The coronary arteries were normal without any significant stenosis and any extrinsic compression. An aortic root injection confirmed the absence of left coronary ostium. Also, a retroesophageal right subclavian artery originating from the left aortic arch (arteria lusoria) was detected as the last branch of aortic arch on contrast enhanced computerized tomography (Figure B-C). The patient discharged with medical therapy.



Figure 1. The left anterior descending (LAD) and circumflex (Cx) arteries arising from proximal part of right coronary artery (RCA) (A), Axial and right anterior oblique images of the retroesophageal right subclavian artery (\*). RCCA: Right common carotid artery LCCA: Left common carotid artery LSC: Left subclavian artery E: Esophagus (B,C)